STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155332	B. WIN			10/01/	2012
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R			CR 200 E		
HERITAG	GE HOUSE REHAE	BILITATION & HEALTHCARE CE	NTEF		ERSVILLE, IN 47331		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	This visit was	for a Recertification and	F00	000	F000 The creation and		
	State Licensur	re Survey.			submission of this plan of		
		,			correction does not constitute		
	Survey dates.	September 25, 26, 27,			admission by this provider of	any	
		•			conclusion set forth in the		
	28, and Octob	GI 1, ZUIZ			statement of deficiencies or of		
	<b>_</b> , .	00005			any violation of regulation. This		
	Facility number				provider respectfully requests the 2567 plan of correction be		
	Provider numb				considered the letter of credib		
	AIM number:	100267670			allegation and request a post		
					certification on or after		
	Survey team:				10-31-2012.We are requesting	ја	
	Barbara Gray,	RN-TC			desk review.		
	Sharon Lashe						
	Leslie Parrett,	·					
	l ' '	5, 26, 27, and October					
	1, 2012)						
	Angel Tomlins	son, RN					
	Census bed ty	rpe:					
	SNF/NF: 83						
	Total: 83						
	Census payor	type:					
	Medicare: 10	<b>31</b>					
	Medicaid: 58						
	Other: 15						
	Total: 83						
		ncies reflect state					
	findings cited i	in accordance with 410					
	IAC 16.2.						
	Quality review	completed on October					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2012 FORM APPROVED OMB NO. 0938-0391

OF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155332	A. BU	ILDING	00	COME	E SURVEY PLETED 1/2012
PROVIDER OR SUPPLIER	I LILITATION & HEALTHCARE CEN		STREET A	DDRESS, CITY, STATE, ZIP C R 200 E RSVILLE, IN 47331	CODE	
GE HOUSE REHAB SUMMARY S' (EACH DEFICIEN	ILITATION & HEALTHCARE CENTATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	B. WI	STREET A	R 200 E	CODE  RECTION HOULD BE	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y5JL11

Facility ID: 000225

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII	DING	00	COMPL	ETED
		155332	A. BUII B. WIN			10/01/	2012
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	t .			CR 200 E		
HERITAC	GE HOUSE REHAB	ILITATION & HEALTHCARE CEN	TEF		ERSVILLE, IN 47331		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	REGULATORY OR  483.15(g)(1) PROVISION OF SOCIAL SERVICE The facility must social services to highest practicab psychosocial wel Based on obse record review, provide treatme of 3 residents in discharge. (Re Findings include Resident #72's on 9/27/12 at 3 included but we dementia, weig failure to thrive  An admission I assessment fo 7/1/12, indicate Resident Mood #72 had felt do trouble falling a asleep, had fel energy, had a overeating, had had trouble con watch televisio she would be to	MEDICALLY RELATED  E provide medically-related attain or maintain the le physical, mental, and l-being of each resident. ervation, interview, and the facility failed to ent for depression for 1 reviewed for community esident #72)  Ie:  Irecord was reviewed E:02 P.M. Diagnoses ere not limited to ght loss, anxiety, and  Interview - Resident own or depressed, had esleep or staying t tired or had little poor appetite or was d felt bad about herself, incentrating to read or in, and had thoughts oetter off dead or of	F02	TAG	F 0250 What corrective action will be accomplished for those residents found to have been affected by the deficient practi On 9/28/12 resident # 72 rece an order for Zoloft 50mg every day. On 10/02/2012 resident # received an order for Psych Evand was seen by Harrison Psychological Consultant on 10/03/12. Social Services and Nursing was in-serviced by Li Lacey RN ED on the following subject matter: theckened lique use of body alarms, the need for monitor negative statements a following up on the need for Psych Services. How will you identify other residents having potential to be affected by the same deficient practice and with corrective action will be taken residents have the potential to affected for PHQ-9 scores of 7 higher and/or Dx. of depression All residents have been review using the MDS for the PHQ scores and or Dx. of depression Those resident's care plans/interventions will be addressed for a PHQ of 7 or above, a Dx. of depression in	(s) ce? ivec 72 val  nda ids, to ind  the hat All be 7 or on. ved	
	#72 had felt do trouble falling a asleep, had fel energy, had a overeating, had trouble conwatch televisionshe would be to	own or depressed, had asleep or staying t tired or had little poor appetite or was d felt bad about herself, incentrating to read or n, and had thoughts better off dead or of at least one day during			corrective action will be taken. residents have the potential to affected for PHQ-9 scores of 7 higher and/or Dx. of depression All residents have been review using the MDS for the PHQ scores and or Dx. of depression Those resident's care plans/interventions will be addressed for a PHQ of 7 or	All be on. wed	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y5JL11

Facility ID: 000225

If continuation sheet

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED	
		155332	B. WIN			10/01/2012	
			b. Will		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	2			CR 200 E		
HERITAC	GE HOUSE REHAB	ILITATION & HEALTHCARE CEN	TEF		ERSVILLE, IN 47331		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	A Social Service	ce note for Resident			Psychiatrist/Psychologist, an		
	#72, dated 9/1	1/12 at 2:11 P.M.,			order for medication, and	4-	
	indicated the fo	ollowing: A Brief			resident-specific interventions assist coping adjustments.	to	
	Interview for M	ental Status (BIMS)			10/31/02Social Services and		
	and Patient He	ealth Questionnaire-9			Nursing in-inserviced by Linda		
	(PHQ-9) was c	completed for Resident			Lacey RD ED on follow up sco		
	, ,	2. Her BIMS score was			of 7 or higher, depression and		
		d Resident #72 had			negative statements.		
		on impairment. Her			10/09/12.What measures will be put into place or what systemic		
	_	was 17 which showed			changes you will make to ensu		
	•	evere depression.			that the deficient practice does		
		nad indicated she felt			not reoccur?The IDT team will		
		of the time due to being			review clinical records during of	care	
	•	She indicated she had			plan meeting to ensure all		
	-	of the time due to			residents with a PHQ of 7 or more/Dx. of depression will ha	VA	
					a care plan/intervention	VC	
	_	d a poor appetite once			developed to address individua	al	
		felt bad about herself			psych needs of the resident.		
		had trouble sleeping			Social Service and Nursing		
		, and had thoughts she			in-serviced by Linda Lacey RN		
		r off dead all of the			ED on follow up Psych service addressing PHQ scores of 7 o		
		t #72 was able to			higher, depression and negative		
		vants and needs			statements.How will the		
		ad a care plan in place			corrective action(s) be monitor		
		energy, appetite,			to ensure the deficient practice		
		hts, and trouble			will not reoccur, i.e., what qual assurance program will be put	-	
	_	Resident #72's BIMS			into place?To ensure compliar		
	· ·	d remained the same			Social Service is responsible f		
		assessment (8/30/12).			the completion of the PHQ's a	nd	
		ook Ativan at bedtime			Psych Services CQI tool weel	kly	
		Ativan every 6 hours			times four weeks, bi-monthly	thly	
		esident #72's would be			times 2 months, and then mon until continued compliance is	lully	
	long term place	ement at the facility and			maintained for 2 consecutive		
	she was accep	iting of the plan.			quarters. The CQI committee		
					overseen by the Ed will review	the	
	A care plan for	Resident #72, dated			results of these audits. If the		

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Event ID: Y5JL11

Facility ID: 000225

If continuation sheet Page 4 of 24

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	NSTRUCTION	(X3) DATE SUR	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPLETE	ED
		155332	B. WIN			10/01/20 <sup>-</sup>	12
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L.			CR 200 E		
HERITAC	GE HOUSE REHAB	ILITATION & HEALTHCARE CEN	TEF		ERSVILLE, IN 47331		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID	, 		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	C	OMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	7/1/12 indicate	ed the following:			threshold of 95% is not achiev	ed.	
		ent #72 made negative			an action plan will be develope		
		. "nothing matters;			to ensure compliance.		
	would rather be	_					
		#72 would not harm					
		ach-Staff would					
		sident #72 to" verbalize					
		oncerns, fears, etc					
	_	served for signs and					
		epression (withdrawal,					
	' '						
	· ·	of appetite, etc)."					
		rk with Resident #72 to					
	I identity effectiv	e coping mechanism.					
	A save plan for	Decident #70 dated					
	•	Resident #72, dated					
		ed the following:					
		ent #72 displayed					
		otoms of mood distress					
		by stating she felt					
	· ·	of the time, had					
	•	g once in awhile, felt					
		ime, had a poor					
	''	n awhile, felt bad about					
		e time, and had					
		hts she would be					
	better of dead						
		stated she would never					
		oal-Resident #72					
		e feelings of underlying					
		. Approach-Staff would					
	acknowledge to	o Resident #72 the					
		n must be difficult.					
	Staff would exp	olore with the Resident					
	past effective a	and ineffective coping					
	mechanisms.	Staff would identify					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y5JL11

Facility ID: 000225

If continuation sheet Page 5 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIT	ILDING	00	COMPI	LETED
		155332	B. WIN			10/01	/2012
		<u> </u>	Γ		ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF P	PROVIDER OR SUPPLIEF	R			CR 200 E		
		BILITATION & HEALTHCARE CE	NTEF		ERSVILLE, IN 47331		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		nat Resident #72 could					
	draw on.						
		9:38 A.M., Resident					
		ved straightening the					
		bed. Resident #72					
		was depressed due to					
		m home. "I guess					
		es through that when					
	they have to le	eave their home." "It is					
	kind of hard liv	ing like this."					
		1:24 P.M., the Director					
	of Nursing (Do	N) indicated Resident					
	#72 had not se	een a therapist related					
	to her depress	ion and was not					
	prescribed any	medication for					
	depression. T	he DoN indicated no					
	documentation	ı was available in					
	Resident #72's	record the physician					
	had been notif	ied of Resident #72's					
	depression or	the physician had					
	addressed her	depression.					
	On 10/1/12 at	9:11 A.M., Social					
	Service (SS) #	3 indicated the family					
	, ,	Resident #72 would					
	voice being de	pressed at times for					
		#3 indicated she had					
	· •						
	1						
		•					
		_					
	Service (SS) # informed her R voice being de attention. SS acare planned R depression. S not taken her c Resident #72's Interdisciplinar	3 indicated the family Resident #72 would pressed at times for #3 indicated she had					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y5JL11

Facility ID: 000225

If continuation sheet Page 6 of 24

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETED	
		155332	B. WIN			10/01/2012	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8			CR 200 E		
HERITAG	GE HOUSE REHAB	ILITATION & HEALTHCARE CEN	ITEF		ERSVILLE, IN 47331		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETI	ION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE	
	physician of Re	esident #72's repeated					
	concerns relate	ed to depression. SS					
	#3 indicated sh	ne had not looked at					
	Resident #72's	depression as					
	worsening, but	now that she looked at					
	-	2's depression had not					
		t had not improved.					
		<sub>1</sub> ,					
	A Social Service	ce Director Position					
	Description pro						
		on 9/28/12 at 2:30 P.M.,					
		ollowing: "Summary of					
		ons-The Social					
	Services Direc						
		•					
		ed social services to					
	attain or mainta	•					
		/sical, mental, and					
		vell-being of each					
	resident. Esse						
		vides assistance to					
	residents in ad	justing to the facility"					
	3.1-34(a)						

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Event ID: Y5JL11

Facility ID: 000225

If continuation sheet Page 7 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING (COMPLETED (A2) A 120					
		155332	B. WING			10/01/	2012
	ROVIDER OR SUPPLIEF	SILITATION & HEALTHCARE CEN	ΓEF	281 S C	ADDRESS, CITY, STATE, ZIP CODE CR 200 E ERSVILLE, IN 47331		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0282 SS=D	CARE PLAN The services provided facility must be propersons in according written plan of cars.  Based on observing the properson of the plan of the pl	ervation, interview, and	F028	82	F-282What corrective action(s		10/31/2012
	record review, follow 1 resided physician's ord to prevent aspir follow 1 resided utilize a bed also for 2 of 24 resided plans and physicians and physicians and physicians included.  1.) Resident #40  Findings included.  1.) Resident #40  A Care Plan for following and was at risk goal-Resident from signs and	the facility failed to ints plan of care and ler for thickened liquids fration and failed to int's plan of care to arm, resulting in a fall, dents reviewed for care sician orders. and #96)  de:  40's record was 0/1/12 at 10:27 A.M. uded but were not eimer's disease with croesophageal reflux ysphagia (difficulty  r Resident #40, dated ted the following: lent #40 required ds related to dysphagia of for dehydration. #40 would be free	1.02	52	will be accomplished for those residents found to have been affected by the deficient practi Resident #40 has a physician order stating "may have 1 Mt. Dew daily". Family members in-serviced on signs/symptoms aspiration due to family reques give resident Mt. Dew when the visit. Nursing staff in-serviced on 10/9/12. In-service done by Linda Lacey RN, ED on mater reviewing thickened liquids. Oplan and aides assignment should be a serviced on 10/9/12. Resident has had an episode of aspiration. 9/27/12Resident#96 alarm replaced after nurse did assessment. Nursing staff educated on need to double check alrms. Nursing staff in-serviced by Linda Lacey RN,ED on 10/9/12 on what alarms are used on each resident and the need to double check alarms are appropriately in place. 10/9/12 How will you identify other residents having potential to be affected by the same deficient practice and who corrective action will be taken? Those residents who are on thickened liquids have the potential to be affected by	ce? s of st to ley ial care lee not the hat	10/31/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y5JL11

Facility ID: 000225

If continuation sheet Page 8 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		155332	B. WIN			10/01/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			CR 200 E		
LIEDITA/	CE HOUSE DEHAR	SILITATION & HEALTHCARE CEN	тсс		ERSVILLE, IN 47331		
HERHA	JE HOUSE KEHAE	SILITATION & FIEAETHCARE CEN	IIEr	CONNE	ERSVILLE, IN 47551		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	monitor Reside	ent #40 for signs and			deficient practice. All resident	S	
	symptoms of d	ehydration and report			on thickened liquids were		
	to the physicia	n. Staff would offer at			reviewed for receiving thin liquids. Physician order in place	00	
	least 1440 mill	iliters of fluid with			and care plans updated. Aide		
	meals. Staff w	ould offer thickened			assignment sheets update. Al		
	fluids between				residents having alarm devices		
		nd with snacks.			were reviewed for proper		
	inculcations, a	na with shacks.			placement. Physician's orders		
	Λ physisian's r	acceptulation order for			and care plans in place. Aides	s'	
		ecapitulation order for			assignment sheets updated.	_	
		or September, 2012,			Charge nurses make rounds of	on	
		y thick liquids with a			each shift for placement of alarms and document on TAR		
	pureed diet, in	itiated on 7/16/12.			Nursing staff in-serviced by Lir		
					Lacey RN, Ed on material		
	On 9/27/12 at	12:05 P.M., Resident			reviewing thickened liquids an	d	
	#40 was obser	ved being fed a pureed			alarms.What measures will be		
	diet with hone	thick water and			put into place or what systemic		
		CNA #4. Resident #40			changes you will make to ensu		
		drinking a thin liquid,			that the deficient practice does		
		, from a can with a			not reccur?Upon admission ar new orders, DNS or Designee		
		indicated Resident			review residents on thickened	VVIII	
					liquids and alarms. Aides'		
	#40 Grafik a ivi	ountain Dew daily.			assignement sheets updated f	or	
	0 40/4/40 1	40.40 D.M. II			aide to be aware. The charge		
		12:49 P.M., the			nurse to make rounds on each		
		sing (DoN) indicated			shift to check and document o		
	Resident #40 v	was not care planned to			the TAR that all alarms in plac	е	
	receive a thin I	iquid Mountain Dew			and resident receiving appropriate thickened liquids.		
	and he did not	have a physician's			Nursing staff in-serviced by Lir	nda	
	order to receiv	e a thin liquid Mountain			Lacey RN, ED on 10/9/12 on	ida	
	Dew.	·			placement of alarms and		
					appropriate thickened liquids.		
	On 10/1/12 at	1:51 P.M., CNA #4			Charge nurse to be in-serviced	•	
		nad given Resident #40			SDC on 10/26/12 on placement	nt of	
		•			alarms, thickened liquids,		
		Mountain Dew because			follow-up for Psych services at		
		hter had said to give			PHQ of score of 7 or higher to	ре	
	him a can if he	was not eating. CNA			addressed by Physician. The		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y5JL11

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If continuation sheet

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2012 FORM APPROVED OMB NO. 0938-0391

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155332	B. WIN		<del></del>	10/01/	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1	CR 200 E		
UEDITA <i>C</i>	DE HOUSE DEHAD	ILITATION & HEALTHCARE CEN	ITEE		ERSVILLE, IN 47331		
HERITAG	JE HOUSE KEHAD	ILITATION & HEALTHCARE CEN	NIEF	COMME	RSVILLE, IN 47331		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	#4 indicated sh	ie knew Resident #40			SDC will provide in orientation	of	
	was ordered th	ickened liquids.			new nursing staff, training of		
	indo ordorod ar	iononiou inquiuo.			placement of alarms and use of		
					thickened liquids. 10/31/12Ho	W	
					will the corrective action(s) be		
					monitored to ensure the deficie		
					practice will not recur, i.e, wha		
					quality assurance program will put in place? To ensure	be	
					compliance, the DNS/Designe	e is	
					responsible for the completion		
					the CQI tool (altered fluid	•	
					consistency) weekly times 4		
					weeks, bi-monthly 2 months ar	nd	
					then monthly until continued		
					compliance is maintained for 2		
					consecutive quarters. The res	ults	
					of these audits will be reviewed	_	
					by the CQI committee oversee		
					by the ED. If threshold of 95%		
					not acheived, an action plan w	111	
					be developed to ensure		
					compliance. 10/31/12		
	,	•					
	Resident # 90	on 9/26/12 at 12:20					
	p.m., indicated	on 9/20/12 at 7:40					
	p.m. "Resident	yelling out for help.					
	·	•					
		•					
	wheelchair bro	ught out of room to					
	common area.	Neuro checks initiated					
	and WNL(withi	n normal limits).					
	•	•					
		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
	On 9/26/12 at <sup>.</sup>	12:32 n m review of					
	Resident # 90 of p.m., indicated p.m. "Resident CNA entered roobserved to be mat. No injury stated he was a wheelchair. Rowheelchair brocommon area. and WNL(within Denies pain/dis	yelling out for help. com and resident was on his knees on fall noted. Resident trying to get to his esident placed in ught out of room to Neuro checks initiated n normal limits).			compliance. 10/31/12		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y5JL11

Facility ID: 000225

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	а. вил	LDING	00	COMPL	ETED
		155332	B. WIN			10/01/	2012
NAME OF D	ROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SOLI LIEI			281 S C	CR 200 E		
HERITAG	SE HOUSE REHAB	BILITATION & HEALTHCARE CEN	TEF	CONNE	ERSVILLE, IN 47331		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	s, dated 9/21/12 at 6:18					
		l "Fall review for					
		) p.m. Resident found					
		n his fall mat beside his					
		had been in bed earlier.					
		d he was getting up to					
	_	eelchair. Alarm was					
		Staff educated to the check alarms before					
	_	om and to ask the					
		s ready to go to bed					
	before laying d	iowii					
	Review on 9/2	7/12 at 10:05 a.m.,					
	indicated "Care	-					
	Problem start of	•					
		risk for fall due to					
	dementia and						
		t will be free from fall					
	related injury tl						
	Approach start						
		to ask resident if he is					
	ready to go to						
	, ,	t date: 12/15/11					
		ed with pressure pad					
	alarm.	•					
	On 10/1/12 at	12:20 p.m., interview					
		(Director of Nursing)					
		alarm pad was not					
		dent # 90's bed before					
	he fell."						
	Davidson 5 1	40/4/40					
		ocument on 10/1/12 at					
	12:30 p.m., pro	ovided by the DON					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y5JL11

Facility ID: 000225

If continuation sheet

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:			00	COMPL	
	155332	A. BUI B. WIN	ILDING NG		10/01	/2012
NAME OF P	PROVIDER OR SUPPLIER		1	ADDRESS, CITY, STATE, ZIP CODE	•	
				CR 200 E		
	GE HOUSE REHABILITATION & HEALTHCARE CEN	IEF		ERSVILLE, IN 47331		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	titled "Fall Management Program"					
	dated "Revised 6/12" indicated					
	"Policy: It is the policy of to ensure					
	residents residing within the facility					
	will maintain maximum physical					
	functioning through the establishment					
	of physical, environmental, and					
	psychosocial guidelines to prevent					
	injury related to falls. PROCEDURE					
	4. Charge nurses will communicate					
	the specific care required for each					
	resident to the assigned caregiver on					
	each shift"					
	0.4.05(.)(0)					
	3.1-35(g)(2)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y5JL11

Facility ID: 000225

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  OO  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		155332	A. BUII B. WIN			10/01/	2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	Щ	
NAME OF P	ROVIDER OR SUPPLIER	L Comments of the Comments of			CR 200 E		
HERITAG	SE HOUSE REHAB	ILITATION & HEALTHCARE CEN	ΓEF		IERSVILLE, IN 47331		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0323	483.25(h)						
SS=D	FREE OF ACCID						
		RVISION/DEVICES ensure that the resident					
	•	ains as free of accident					
		ssible; and each resident					
	receives adequat	e supervision and					
		es to prevent accidents.					
		ervation, interview, and	F03	23	F323What corrective action(s)	will	10/31/2012
		the facility failed to			be accomplished for those		
	provide 1 resid	ent with thickened			residents found to have been affected by the deficient practi	ice?	
	liquids to preve	ent aspiration and failed			Resident # 40 has a Physiciar		
	to provide 1 res	sident with a bed			order for 1 Mt. Dew a day. Fa		
	alarm, resulting	g in a fall, for 2 of 4			members in-serviced for signs		
	residents review	wed for accidents.			and symptoms of aspiration.		
	(Resident #40	and #96)			Nursing staff in-serviced by Li Lacey RN, ED on 10/9/12.	nda	
	Findings includ	le:			Material covered on who has thickened liquids, signs/symptoms of aspiration.		
	1 ) Resident #4	10's record was			Aides' assignment sheets		
	•	0/1/12 at 10:27 A.M.			updated. Care plan updated.		
		uded but were not			10/31/12Resdent # 96 alarm		
	•	eimer's disease with			replaced after the nurse completed her assessment.		
		roesophageal reflux			Nursing staff educated on nee	ed to	
	. •	ysphagia (difficulty			double check alarms. The		
	swallowing).	yspriagia (difficulty			charge nurse instructed the st	aff	
	Swallowing).				to check all alarms on other		
	A Cara Dian fo	r Dooidant #40 datad			residents for placement. All		
		r Resident #40, dated			alarms were in place on the of residents. 9/26/12How will yo		
		ted the following:			identify other residents having		
		ent #40 required			potential to be affected by the		
	-	ds related to dysphagia			same deficient practice and w	hat	
		for dehydration.			corrective action will be taken		
		#40 would be free			Those residents who have ala		
	from signs and	• .			may have the potential of bein affected by deficient practices		
	-	Approach-Staff would			residents on thickened liquids		
	monitor Reside	ent #40 for signs and			were reviewed for receiving th		

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Event ID: Y5JL11

Facility ID: 000225

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00	COMPLETED	
155332 A. BUILDING	10/01/2012	
B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER  281 S CR 200 E		
HERITAGE HOUSE REHABILITATION & HEALTHCARE CENTEF CONNERSVILLE, IN 47331		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	DATE	
symptoms of dehydration and report liquids. Physician orders in plant and agree plants and agree plants.		
to the physician. Staff would offer at  and care plans updated as we as the aides' assignment shee		
least 1440 milliliters of fluid with  All residents who have alarm	7.5.	
meals. Staff would offer thickened devices were audited for proper	er	
fluids between meals, with placement. Last 90 days of		
medications, and with snacks. incident reports reviewed.		
Physician order in place and c	are	
A Speech Therapist Progress and plans updated as well as the		
alues assignement sheets.		
Discharge Summary for Resident Nursing staff in-serviced by Lir #40, dated 7/11/12, indicated the Lacey RN, ED on 10/09/12 on		
of clarms What massures will		
training-Stail were educated on put into place or what systemic		
Resident #40 not being able to changes you will make to ensu	ure	
upgrade to a regular diet with thin that the deficient practice does		
liquids due to a mechanical soft diet not recur. The DNS or Designe	<b>I</b>	
with thick liquids being the safest by	<b>I</b>	
mouth intake for Resident #40.	je	
communicate through report to	,	
A physician's recapitulation order for aides which residents on		
Resident #40 for September, 2012, thickened liquids and alarms.		
indicated honey thick liquids with a Charge nurse to check and		
nursed diet initiated on 7/16/12 document on the TAR all alrms	s in	
place and residents receiving		
appropriate thickened liquids.		
Resident #40's Minimum Data Set  (MDS) Assessment dated 8/31/12  Nursing staff in-serviced on 10/9/12 by Linda Lacey RN, E	n	
(MDC) / 100000 More, dated 0/0 // 12,		
nlacement of alarms. Charge		
extensive assistance of 1 person to   nurses to be in-serviced by SE		
eat. Resident #40 coughed or on 10/26/12 on thickened liqui		
choked during meals or when and placement of alarms. How	will	
swallowing medications. the corrective action(s) be		
monitored to ensure the deficie	<b>I</b>	
A quarterly MDS review progress note practice will not recur, i.e., who quality assurance program will		
for Resident #40, dated 8/31/12 at put in place?To ensure		
3:56 P.M., indicated the following: compliance, the DNS/Designe	ee	
Resident #40 required a pureed diet is responsible for the ceomple		

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIC	00	COMPLETED
		155332		LDING		10/01/2012
			B. WIN		ADDRESS CITY STATE ZID CODE	
NAME OF P	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE	
LIEDITAG	SELIOLIOE DELLAD	ULITATION O LIEALTHOADE OFNI			CR 200 E	
HERITAG	SE HOUSE REHAB	ILITATION & HEALTHCARE CEN	IEF	CONNE	ERSVILLE, IN 47331	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	with honey thic	k liquids related to			of the CQI tool, Residents' Ala	rm
	dysphagia. Sp	eech Therapy had			systems/Wanderguards,	
	treated and att	empted to upgrade			(attached) weekly tines 4 week	
		diet without success.			bi-monthly times 2 month, and	
		seemed to tolerate his	1		then monthly until continued compliance is maintained for 2	,
		diet with honey thick			consecutive quarter. The resu	
	-	-	1		of these audits will be reviewed	l l
	•	uids were encouraged			by the CQI committee, oversed	
	•	staff. Resident #40			by the ED. If threshold of 95%	
		ough at times with			not achieved, an action plan w	ill
	intake of food of	or medications.			be developed t ensure	
					compliance.	
	On 9/27/12 at	12:05 P.M., Resident				
	#40 was obser	ved being fed a pureed				
		thick water and				
		CNA #4. Resident #40				
	_					
		drinking a thin liquid				
		from a can with a				
		indicated Resident				
	#40 drank a Mo	ountain Dew daily.				
	On 10/1/12 at <i>1</i>	12:49 P.M., the				
	Director of Nur	sing (DoN) indicated	1			
	Resident #40 v	vas not care planned to				
	receive a thin I	iquid Mountain Dew				
		have a physician's				
		e a thin liquid Mountain				
		I indicated she was not				
		at #40 had received a				
	thin liquid Mou	ntain Dew.				
			1			
		1:51 P.M., CNA #4				
	indicated she h	nad given Resident #40				
	the thin liquid N	Mountain Dew because				
	•	nter had said to give				
		was not eating. CNA				
		was not cating. ONA	1			

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Event ID: Y5JL11

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155332	B. WIN			10/01/	2012
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹		281 S C	CR 200 E		
HERITAGE HOUSE REHABILITATION & HEALTHCARE CEN		ITEF		ERSVILLE, IN 47331			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	#4 indicated sh	ne knew Resident #40					
	was ordered th	nickened liquids.					
		·					
	A CNA assignr	ment sheet provided by					
	_	/1/12 at 2:00 P.M.,					
		dent #40 was to receive					
	honey thickene	eu iiquias.					
	0 \ D	Luncius and S					
	· ·	Nursing notes for					
		on 9/26/12 at 12:20					
		on 9/20/12 at 7:40					
	p.m. "Resident	yelling out for help.					
	CNA entered re	oom and resident was					
	observed to be	e on his knees on fall					
		noted. Resident					
		trying to get to his					
		esident placed in					
		•					
		ught out of room to					
		Neuro checks initiated					
	,	n normal limits).					
	Denies pain/dis	scomfort."					
	On 9/26/12 at	12:32 p.m., review of					
	Progress notes	s, dated 9/21/12 at 6:18					
	p.m., indicated	"Fall review for					
	•	p.m., Resident found					
		n his fall mat beside his					
		had been in bed earlier.					
		d he was getting up to					
	_	eelchair. Alarm was					
		Staff educated to the					
	need to double	check alarms before					
	leaving the roo	m and to ask the					
	_	s ready to go to bed					
		lown. Staff to ask					
		Clair to don					

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Event ID: Y5JL11

Facility ID: 000225

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		155332	B. WIN			10/01/2012
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	t .			CR 200 E	
HERITΔC	SE HOUSE REHAR	ILITATION & HEALTHCARE CEN	ITEE		ERSVILLE, IN 47331	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE
		when he normally went				
	to bed at home	e. No injuries noted				
	and denies pai	n. Resident's fall was				
	unwitnessed, n	eurochecks initiated				
	and WNL. Res	sident was fully				
	dressed with n	on-skid socks on. No				
		factors noted to				
		III. Glucose was 191				
	without signs o					
	_	. Wife and MD has				
		of fall. Alarm was put				
		•				
	•	Wife states bedtime				
	•	om at home. Staff will				
		r time for resident to go				
	to bed if agreea	able with resident."				
	Review on 9/27	7/12 at 9:30 a.m. of				
	"Event Report"	documentation, dated				
	9/20/12 at 7:20	a.m., indicated				
	"Describe what	t Resident was doing				
		ng in bed. Resident or				
	witness statem	•				
	occurred: Tryin					
	-	hat intervention was				
		o prevent another fall.				
	•	-				
		n, ask Resident if he is				
		bed. Alarm to be in				
	place before le	aving room."				
		7/12 at 10:05 a.m.				
	indicated "Care	•				
	Problem start of	date: 7/24/11				
	Resident is at r	risk for fall due to				
	dementia and f	fall history.				
		will be free from fall				

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Event ID: Y5JL11

Facility ID: 000225

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) N	IUL HPLE CO	OO	(X3) DATE COMPL	
AND PLAN	155332		ILDING	00	10/01/	
	133332	B. WIN			10/01/	∠∪ 1∠
NAME OF F	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE  281 S CR 200 E				
HERITA <i>(</i>	GE HOUSE REHABILITATION & HEALTHCARE CEN	TEE		:R 200 E :RSVILLE, IN 47331		
		1	<u> </u>			avs)
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	related injury thru reviews.	1				
	Approach start date: 9/20/12					
	Staff educated to ask resident if he is					
	ready to go to bed.					
	Approach start date: 6/23/12					
	Staff to check for needs every 2					
	hours.					
	Approach start date: 4/10/12					
	Pressure pad alarm replaced related					
	to non-functioning.					
	Approach start date: 2/27/12					
	Continue current interventions,					
	successful in preventing injury.					
	Approach start date: 12/28/11					
	Frequent staff checks while resident					
	in room.					
	Approach start date: 12/15/11					
	Pull tab replaced with pressure pad					
	alarm.					
	Approach start date: 12/12/11					
	Fall mat					
	Approach start date: 12/12/11  Low bed with perimeter mattress.					
	Approach start date: 7/24/11					
	Assist with all mobility and transfers.					
	Approach start date: 7/24/11					
	Call light in reach with cues to use.					
	Approach start date: 7/24/11					
	Non skid footwear.					
	Approach start date: 7/24/11					
	Personal items in reach.					
	Approach start date: 7/24/11					
	Therapy screen."					
	On 10/1/12 at 10:20 a.m., interview					

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Facility ID: 000225

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155332	B. WIN			10/01/	2012
			-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R		281 S C	R 200 E		
HERITAGE HOUSE REHABILITATION & HEALTHCARE CEN		NTEF	CONNE	ERSVILLE, IN 47331			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	with CNA # 2 i	ndicated "I always					
	check the chai	r and bed pad alarm					
	anytime I do ca	are on residents. The					
	nurse checks i	t every shift and					
	documents she	e checked it on the					
	treatment form	. Resident # 90 uses					
		n his bed as well as in					
	his chair."						
	Interview with	LPN # 1 on 10/1/12 at					
		dicated "the nurses					
	•	shifts 7 a.m. to 7 p.m. I					
		•					
		the chair and bed					
		m doing med pass or					
		ring the first half of the					
		cated she has also					
		ift and does the chair					
	and bed alarm	checks while they are					
	putting the resi	idents to bed. There is					
	no area on trea	atment form to					
	document the	time the checks were					
	made, just the	shift they were done					
	on."	•					
	On 10/1/12 at	12:20 p.m., interview					
		ector of Nursing)					
	,	eries are replaced					
		tion is checked and if it					
		aff will replace it. No					
	· ·	• • • • • • • • • • • • • • • • • • •					
		ime to replace them,					
	1 -	get low. Staff replace					
		s needed." The DON					
		alarm pad was not					
	placed in Resid	dent # 90's bed before					
	he fell."						

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Event ID: Y5JL11

Facility ID: 000225

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:  155332		LDING	00	COMPL 10/01/	ETED
NAME OF PROVIDER OR SUPPLIER  HERITAGE HOUSE REHABILITATION & HEALTHCARE CEN		ГЕБ	281 S C	ddress, city, state, zip code R 200 E RSVILLE, IN 47331			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	12:30 p.m., protitled "Fall Mandated "Revised" "Policy: It is the residents residwill maintain mfunctioning throof physical, enupsychosocial ginjury related to PROCEDURE.  4. Charge nurs the specific car						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y5JL11

Facility ID: 000225

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155332	B. WIN			10/01/2012	
			D. WIIV	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					CR 200 E		
HERITAC	GE HOUSE REHAB	ILITATION & HEALTHCARE CEN	ΓEF		ERSVILLE, IN 47331		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	483.45(a) PROVIDE/OBTAI SERVICES If specialized rehabut not limited to, speech-language therapy, and menservices for menteretardation, are recomprehensive plant provide the require required services (in accordance wifrom a provider of services.  Based on observices. Based on observices record review, provide psychia residents review Screening and (PASRR). (#52) Findings included Resident #52's on 9/28/12 at 1 included but we dementia- probanxiety, depreservices retardation.  A Psychological Resident #52, condicated the foreview-Assessing and control of the proview of th	IN SPECIALIZED REHAB  abilitative services such as, physical therapy, pathology, occupational stal health rehabilitative al illness and mental equired in the resident's lan of care, the facility must red services; or obtain the from an outside resource ith §483.75(h) of this part) if specialized rehabilitative ervation, interview, and the facility failed to atric services for 1 of 3 wed for Preadmission Resident Review  2)  de:  record was reviewed 0:46 A.M. Diagnoses ere not limited to bable Alzheimer's type, asion, and mental  al Service note for dated 11/8/11, ollowing: "Reason for current levels of	F04	TAG	F 406What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practic Resident # 52 received an ord for Psych Services and was set by Harrison Psychological Consultation on 10/3/12. Care plan updated. 10/3/12Social Service and Nursing staff in-serviced by Linda Lacey RNED on 10/9/12. Material cover on need to have follow-up services be provided on reside coming from a Psych Unit, or have received Psych Services the past and to monitor PASRI for Level II. 10/9/12How will yill identify other residents having potential to be affected by the same deficient practice and who corrective action will be taken? residents have the potential to affected by the deficient practice. All residents were reviewed who was admitted from a Psych Unit or has been on a	ce? er een e	

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NAME OF PROVIDER OR SUPPLIER  HERITAGE HOUSE REHABILITATION & HEALTHCARE CENTEF  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  With revaluation in approximately 3 months; consistent with Level 2. Continue with current behavioral protocols."  A BOILDING BY WIND SUMMARY STATEMENT OF DEFICIENCIES ID RECORDER OF THE APPROPRIATE OF DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  A Social Service Qualified Mental Retardation Professional (QMRP) note for Resident #52, dated 3/2/12, indicated the following: Resident #52 was taking psychiatric medications including Zoloft for depression, trazodone for insomnia, and Seroquel for behaviors. His primary behavioral
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I for penaviors. His primary penavioral I I I I I I I I I I I I I I I I I I I
to monitor the need for a Level in
difficulty was becoming physically to be completed upon admission
aggressive with staff during care. He or within 30 days of admission.
was also noted to have periods of 10/31/12Social Services will audit
irritability. His most recent psychiatric all residents coming from a Psych
Office visit was Nevember 2011
convices doing the Triagney of
CQI form. Upon admission, A Developmental Disabilities Social Services will monitor. The
The second secon
Service-individual Support Fiati/Case
Conference/Review, dated 3/18/12, to ensure all residents have
indicated Resident #52's identified follow-up Psych Services
needs included psychiatric services. indicated from a Level II or
admitted from a Psych Unit.
Resident #52's quarterly Minimum
Data Set (MDS) assessment, dated action(s) be monitored to ensure
the denoted practice will be recur,
io, what quality accuration
no mood or behaviors.  program will be put into place?To
ensure compliance, Social Services is responsible for the
Resident #52 significant change MDS completion of the PHQs and
assessment, dated 7/20/12, indicated Psych Services CQI tool weekly
the following: Mood-Resident #52 times 4 weeks, bi-monthhly times
had a poor appetite or overate in the 2 months, and then quarterly until
last 2 to 6 days. Resident #52 began

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
		155332		LDING	- <u>-</u> -	10/01/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	₹					
LIEDITAC	DE HOUSE DEHAR	DILITATION & HEALTHCARE CEN	TEE		CR 200 E ERSVILLE, IN 47331		
ПЕКПАС	SE NOUSE RENAE	BILITATION & HEALTHCARE CEN	IEr	COMME	RSVILLE, IN 47331		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	being short ter	npered and easily			maintained for 2 consecutive		
	annoyed for th	e last 2 to 6 days.			quarters. The results of these		
					audits will be reviewed by the committee overseen by the EI		
	On 9/27/12 at	12:15 P.M., Resident			threshold of 95% is not achiev		
	#52 was obser	ved seated in his			an action plan will be developed		
		he dining room. CNA			to ensure compliance.		
		ed making numerous					
		t Resident #52 to eat.					
		would turn his head and					
		his hands. CNA #6					
	•						
		etimes after staff					
	_	him he would begin					
	_	elf, it depended on his					
	mood.						
	On 10/1/12 at	9:24 A.M., Memory					
	Care Facilitato	r (MCF) #7 indicated					
	per her phone	conversation with one					
	of the psychiat	ric service staff on					
	• •	st time they were in the					
		ices, Resident #52 had					
	_	e building. MCF #7					
		sychiatric service staff					
		Resident #52 would be					
		toolaont noz woala bo					
		2 or no later than the					
	_	. MCF #7 indicated the					
	_	en having difficulty with					
	residents not b	•					
	• •	vices and the facility					
	was in the prod	cess of looking into					
	changing servi	ce providers due to					
	residents need	ling more support from					
		MCF #7 indicated she					
		racking resident's					
		ts. MCF #7 indicated					
	poyonianio visi	is. Moi #1 indicated					

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/01/2012
	PROVIDER OR SUPPLIER  SE HOUSE REHABILITATION & HEALTHCARE CENT	281 S (	ADDRESS, CITY, STATE, ZIP CODE CR 200 E ERSVILLE, IN 47331	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	the last time Resident #52 received psychiatric services was in November, 2011.			
	3.1-23(a) 3.1-23(a)(1) 3.1-23(a)(2)			

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